St. Bartholomew's Hospital Journal.

"Æquam memento rebus in arduis
Servare mentem."
—*Horace*, Book ii, Ode iii.

VOL. XLI.—No. 3.] DECEMBER 1ST, 1933. PRICE NINEPENCE.

CALENDAR.

Fri., Dec. 1.—Lord Horder and Sir Charles Gordon-Watson on duty.
Sat., ,, 2.—Rugby Match *v.* Rosslyn Park. Home. Association match *v.* Harrods. Away. Hockey match *v.* Broxbourne. Away.
Mon., ,, 4.—Special subject: Clinical Lecture by Mr. Elmslie.
Tues., ,, 5.—Dr. Hinds Howell and Mr. Harold Wilson on duty.
Wed., ,, 6.—Surgery: Clinical Lecture by Sir Charles Gordon-Watson.
Rugby Match *v.* R.M.A. Woolwich. Away.
Fri., ,, 8.—**Inspection of New Medical College by H.R.H. The Prince of Wales, 3.30 p.m.**
Medicine: Clinical Lecture by Dr. Graham.
Dr. Gow and Mr. Girling Ball on duty.
Sat., ,, 9.—Rugby Match *v.* Northampton. Away. Association Match *v.* Old Brentwoods. Home. Hockey Match *v.* Surbiton II. Away.
Mon., ,, 11.—Special Subjects: Clinical Lecture by Mr. Just.
Tues., ,, 12.—Dr. Graham and Mr. Vick on duty.
Wed., ,, 13.—Surgical Lecture by Sir Charles Gordon-Watson.
Fri., ,, 15.—Medicine: Clinical Lecture by Dr. Graham.
Prof. Fraser and Prof. Gask on duty.
Sat., ,, 16.—Rugby Match *v.* Old Paulines. Away. Association Match *v.* Old Foresthillians. Away. Hockey Match *v.* R.N.C. Greenwich. Away.
Tues., ,, 19.—**Last day for receiving matter for the January issue of the Journal.**
Lord Horder and Sir Charles Gordon-Watson on duty.
Fri., ,, 22.—Dr. Hinds Howell and Mr. Harold Wilson on duty.
Mon., ,, 25.—**Christmas Day.**
Tues., ,, 26.—BOXING DAY. Dr. Gow and Mr. Girling Ball on duty.
Fri., ,, 29.—Dr. Graham and Mr. Vick on duty.
Sat., ,, 30.—Rugby Match *v.* Redruth. Home.

EDITORIAL.

ONCE again the Festive Season is upon us and the Surgery already echoes the sounds of song and dance, while Sisters secretly plan new modes of decoration for the wards.

Each Christmas reveals a store of latent talent—the most reticent dresser is sometimes the best comedian, and the plainest Resident the most amorous chorus girl. Santa Claus, we have long observed, is a profound psychologist; he removes the deepest inhibitions and repressions.

The rehearsing of Christmas shows fills one with depression, it is worse than Gee Street on a winter's night. Nobody knows their part, the leading lady sings flat and the producer finally retires with melancholia. Only those who have attempted any such production can appreciate this dreadful dilemma, but beginners need not be discouraged, the final result is inevitably good, provided the cast contains a versatile pianist and a barrel of beer.

There are fashions in medicine just as there are fashions in clothes: a drug that is used to-day will be thrown aside to-morrow. Mistletoe has recently been boosted, in a proprietary form, as a hypopietic, but we have so far no experience of this action; we can, however, recommend it as an amorfacient when applied externally.

We wish all our readers a happy Christmas, and would remind them of the College Appeal Fund when sending out their presents.

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The Dean has asked us to announce that His Royal Highness, the Prince of Wales, will visit the Charterhouse Square site on the afternoon (3.30 p.m.) of Friday, December 8th. It is hoped that all students will turn up to greet him.

* * *

COLLEGE APPEAL FUND.

	£	s.	d.		†
Staff	12,246	5	9	(70)	
Demonstrators	1,519	11	0	(65)	
Students	494	1	6	(262)	
Old Bart.'s men:					
Bedfordshire	10	10	6	(2)	(26)
Berkshire	86	1	0	(13)	(37)
Buckinghamshire	72	17	0	(12)	(29)
Cambridgeshire	165	14	0	(13)	(42)
Cheshire	1	1	0	(1)	(26)
Cornwall	22	2	0	(5)	(36)
Cumberland	5	0	0	(1)	(6)
Derbyshire	19	14	0	(4)	(17)
Devonshire	539	17	0	(49)	(117)
Carried forward	£15,182	14	9		

	£	s.	d.		
Brought forward	15,182	14	9		
Dorset	52	1	0	(14)	(30)
Durham	16	6	0	(3)	(11)
Essex	228	18	6	(16)	(69)
Gloucestershire	218	12	6	(20)	(66)
Hampshire	406	14	0	(38)	(134)
Herefordshire	13	3	0	(4)	(11)
Hertfordshire	73	0	0	(12)	(73)
Huntingdonshire					(1)
Isle of Wight	176	13	0	(11)	(25)
Kent	554	0	0	(62)	(146)
Lancashire	91	2	0	(11)	(82)
Leicestershire	133	12	0	(6)	(28)
Lincolnshire	44	3	0	(12)	(25)
Middlesex	382	3	0	(18)	(68)
Norfolk	159	7	6	(18)	(60)
Northamptonshire	54	4	0	(4)	(17)
Northumberland	101	1	0	(2)	(11)
Nottinghamshire	13	13	0	(2)	(28)
Oxfordshire	177	0	0	(16)	(29)
Rutland					(2)
Shropshire	35	9	0	(8)	(22)
Somersetshire	463	10	0	(26)	(43)
Staffordshire	194	18	0	(6)	(37)
Suffolk	263	1	0	(16)	(46)
Surrey	418	5	6	(42)	(180)
Sussex	250	10	0	(42)	(170)
Warwickshire	177	0	6	(17)	(56)
Westmorland	1	0	0	(1)	(5)
Wiltshire	97	11	0	(11)	(26)
Worcestershire	146	12	6	(19)	(27)
Yorkshire	258	2	6	(20)	(101)
Wales	43	1	0	(9)	(150)
London	2,564	1	8	(166)	(971)
Channel Islands	10	0	0	(1)	(9)
Scotland	14	4	0	(4)	
Abroad	38	5	0	(7)	
South Africa	324	0	6	(16)	
Canada	113	2	6	(8)	
East Africa	62	7	0	(6)	
West Africa	146	10	0	(5)	
India	152	0	0	(7)	
Ceylon	4	0	0	(1)	
Syria	2	2	0	(1)	
U.S.A.	5	0	0	(1)	
Ireland	14	14	0	(3)	
North Africa	1	0	0	(1)	
North Borneo	5	5	0	(1)	
Australia	12	2	0	(3)	
Egypt	2	2	0	(1)	
Malay States	6	0	0	(2)	
China	45	7	4	(7)	
Siam	10	0	0	(1)	
France	50	0	0	(1)	
Trinidad	20	0	0	(1)	
British West Indies	23	1	0	(3)	
Kenya	10	0	0	(2)	
New Zealand	1	1	0	(1)	
Services	514	14	0	(33)	
Others	22,093	8	7	(224)	
	£46,671	16	10		

† Number of Bart.'s men in County.

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The appearance of the current volume of the *St. Bartholomew's Hospital Reports* brings to a close the Joint Editorship of Mr. W. Girling Ball, who has held office during the last nine years. The present volume is quite one of the best that has been so far produced, and speaks highly for the work of the Editors. It is hoped that new subscribers will be forthcoming; the annual subscription is only 15*s*.

Contents:

In Memoriam:

Richard Gill, M.B., F.R.C.S. By Sir D'Arcy Power.

Symposium on Sympathectomy:

(*a*) Demonstration of the Anatomy of the Sympathetic Nervous System. By R. E. Norrish.

(*b*) Demonstration of the Results of Sympathectomy:

(i) Pre-sacral Neurectomy for Spasmodic Dysmenorrhœa. By Malcolm Donaldson.

(ii) Pre-sacral Neurectomy for Hydro-ureter. By R. Ogier Ward.

(iii) Sympathectomy for Idiopathic Megalocolon. By G. Naunton Morgan.

(iv) Sympathectomy for Chronic Gastric Ulcer. By J. Basil Hume.

(v) Sympathectomy for Raynaud's Disease. By Prof. George E. Gask.

(vi) Sympathectomy for Chronic Arthritis. By John P. Hosford.

(vii) Sympathectomy for Raynaud's Disease, Causalgia and Angina Pectoris. By J. Paterson Ross.

Report from the Follow-up Department of St. Bartholomew's Hospital:

(*a*) An Investigation into the End-results in the Treatment of Cancer of the Breast.

(*b*) A Study of Cancer of the Buccal Cavity with the End-results of Treatment.

Observations on the Health of a Nursing Staff. By William P. S. Branson.

Pre-Reformation Nurses in England. By Miss Margaret H. Hart.

Maternal Obstetrical Paralysis. By John Beattie.

The Clinical Chemistry of Alkaptonuria and Melanogenuria. By G. A. Harrison.

Inhibitory Selective Culture Media. By Lawrence P. Garrod.

Tissue Culture in its Relationship to Surgical Pathology. By H. J. Burrows.

The Blood Urea Clearance Test. By W. G. Oakley.

The Life and Works of Percivall Pott. By G. M. Lloyd.

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We are asked to announce that the Amateur Dramatic Society will produce their annual entertainment in the Great Hall from Tuesday, January 16th, to Friday, January 19th.

They have chosen John Drinkwater's play, *Bird in Hand*, as their production; this will be preceded by a short curtain-raiser by "Saki", called *The Death Trap.*

THE ST. BARTHOLOMEW'S HOSPITAL GOLFING SOCIETY.

The St. Bartholomew's Hospital Golfing Society held their Sixth Autumn Meeting at Denham Golf Club on September 20th. The weather was perfect, and 23 members took part in the competitions. Seventeen stayed on for supper, and all enjoyed an excellent day's golf.

The results were as follows:

Milsom Rees Cup.

1st. Sir Milsom Rees . . All square.
2nd. E. Fletcher . . . 1 down.
3rd. R. S. Corbett . . 2 down.

Last 9 holes:

Sir Milsom Rees . . . All square.
K. F. D. Waters, T. H. Just, L. Jameson Evans, R. S. Corbett . . 2 down.

Sealed holes:

Sir Milsom Rees, R. S. Corbett, H. J. White . . 1 up.

Foursomes.

J. V. Sparks and C. Wroth; L. Jameson Evans and G. Wynne Thomas } 4 down.

First 9 holes:

L. Jameson Evans and G. Wynne Thomas; A. C. Roxburgh and H. Bedford Russell; G. Graham and E. M. Darmady } 2 down.

Sealed holes:

J. V. Sparks and C. Wroth . . 1 down.
H. J. White and T. Meyrick Thomas . 2 down.

As Sir Milsom Rees did not wish to win his own Cup, it was awarded to Dr. E. Fletcher.

* * *

We have been asked to announce that the Bart.'s Busy Bees are holding their annual Christmas Party on Saturday, December 30th, at the Portman Rooms, Baker Street, W.1. It is hoped that every Bee and every friend of the Bees will swarm to the party. Fancy dress is optional, and there will be endless attractions for all ages.

Tickets are obtainable from Mrs. Geoffrey Evans, 23, Park Square East, N.W. 1.

ACKNOWLEDGMENTS.

The British Journal of Surgery—The Nursing Times—Charing Cross Hospital Gazette—Guy's Hospital Gazette—Magazine of the London Royal Free Hospital—Middlesex Hospital Journal—St. Mary's Hospital Gazette—St. Thomas's Hospital Gazette—The Student—University College Hospital Magazine—King's College Gazette—University of Toronto Medical Society Magazine—Clinical Journal—East African Medical Journal—The General Practitioner—The Hospital—Bulletins et Mémoires de la Société Médecine de Paris—L'Echo Médicale du Nord—The Medical Forum—The Medical Press and Circular—Medical Times and Long Island Medical Journal—Post-graduate Medical Journal—Reale Società Italiana D'Igiene—Revue Belge des Sciences Medicales—Archives Hospitalières.

§

A SHORT REVIEW ON RECENT WORK, ESPECIALLY THE OPERATIONS FOR THE CURE OF DETACHMENT OF THE RETINA.

I HAVE chosen the above subject for my short paper, as I feel that everyone, whatever branch of medicine or surgery he may be practising, will be interested in the wonderful advance that has been made in the treatment and cure of the dread disease, detachment of the retina. It is only a few years ago that one practically had to say, "I am afraid there is no hope of a cure".

In 1904 Prof. Marc Dufour, who was President of the Tenth International Congress of Ophthalmology, held at Lucerne, in his opening speech asked particularly if there would never be a "direct method of attaching the retina", and he blessed in advance the man who would bring news of this nature to a future conference.

No doubt he would have felt great satisfaction in knowing that one day, in his own clinic, very encouraging observations would be made in the direction he was hoping. In fact, although retinal detachment had been known for fifty years, in its clinical manifestations, its treatment was no more advanced than in the first days of its examination with an ophthalmoscope

The usual failures in attempting to cure the disease by lying in bed for weeks, with a compression bandage, by methods of producing copious sweating and subconjunctival injections, or more direct interventions, such as scleral punctures and draining the subretinal space, not without mentioning the more difficult injection of tincture of iodine into the vitreous, had given retinal detachment the reputation of being an incurable disease.

This reputation was hardly modified up till as late as 1929, and in spite of new methods which had been put into practice. Proof of this was to be found in all ophthalmic manuals, giving relapses—as a general rule—whatever treatment was applied.

Dr. Vail, in working out statistics in America, came to the conclusion that only about one case in a thousand was cured, and he therefore concluded that it would be as well to give up all slightly active treatment so long as no really curative method was known.

During the years 1904–1929 Prof. Gonin, of Lausanne, had been steadily working on the subject of the pathology of the retinal detachment, and had come to such definite conclusions as to a tear causing detachment of the retina that he actually performed a cautery puncture to close the tear as far back as 1916. He proved to his own satisfaction that the great majority of detached retinæ were due to holes occurring in the retina which

allowed the vitreous, which was more fluid in this case, to enter into the tear and separate the retina from the choroid.

In spite of numerous papers which Gonin wrote, and although observers found the tear in a great number of detachments, not much notice was taken of his theory. Some authorities said the fact of the tear being present made the case hopeless as regards treatment; others said that the fluid must be removed and the retina re-attached irrespective of the tear. The author well remembers, when he visited Lausanne in 1930, the pride with which Gonin showed a beautiful specimen of an eye with a detachment where one could see the hole in the detachment, and the piece of the retina—the size of the tear—which was loose in the vitreous in the vicinity of the tear.

It was not till June, 1928, at the meeting of the Swiss Ophthalmological Society, that Gonin had the pleasure of hearing Prof. Vogt, of Zurich, and Prof. Sigrist, of Berne, confirm his results, which proved that closing of the tear in the retina cured the detachment. Since then Prof. Vogt has written a very fine monograph in the *Klinische Monatsblätter für Augenheilkunde*, which was published in 1929, and also another paper in 1930, which continued his series of cases, and added many important observations and cures; both these papers should be read by anyone interested in the early work on detached retina. Also, Prof. Arruga, of Barcelona, has published a very full paper with excellent drawings in the *Archivos de Oftalmologia*, October, 1929.

Gonin himself showed eight cured cases in Heidelberg at the German Ophthalmological Congress; this especially brought his work before all the well-known German surgeons. The result of all this work was the triumph of Gonin at the International Congress held at Amsterdam in 1929. At last his wonderful work was recognized and Dufour's wish was realized.

I have gone rather fully into the history of the early operative work of detachment of the retina, as one feels that whatever brilliant methods have since been evolved, Gonin stands out as the man who focused the eyes of the ophthalmological world on the possibility of operating and getting cures in detachment of the retina.

After the Ophthalmological Congress of 1929, surgeons all over the world began to do the operation. Sir William Lister and Mr. Goulden, of the Royal London Ophthalmic Hospital, introduced the operation into England in the latter part of 1929.

Though many cures were obtained, several surgeons felt that the method was associated with great dangers, such as a vitreous hæmorrhage, secondary tears and softening of the globe; also, the method needed very great care in the finding and exact marking of the tear.

This led to fresh methods being tried. First, there were the chemical methods of Guist, of Vienna, and also of Rubbrecht, of Bruges, the latter surgeon, though less known, doing some very careful work. Guist, after trephining and exposing the choroid, touched the choroidal tissue with caustic potash, finally perforating one of the many trephinings in order to let out the subretinal fluid. Lindner slightly modified and extended the method, writing a long monograph on the Lindner-Guist method. This method held sway for a short time, and was done most beautifully by Mr. Black, then Senior House Surgeon at Moorfields. There were many drawbacks to this method, the length of the operation and the many trephinings being liable to cause weakening of the sclerotic. The method used by Rubbrecht was the injection of jequiritol in various strengths. He claimed some successes, but to me the method seemed dangerous, as the reaction was very severe.

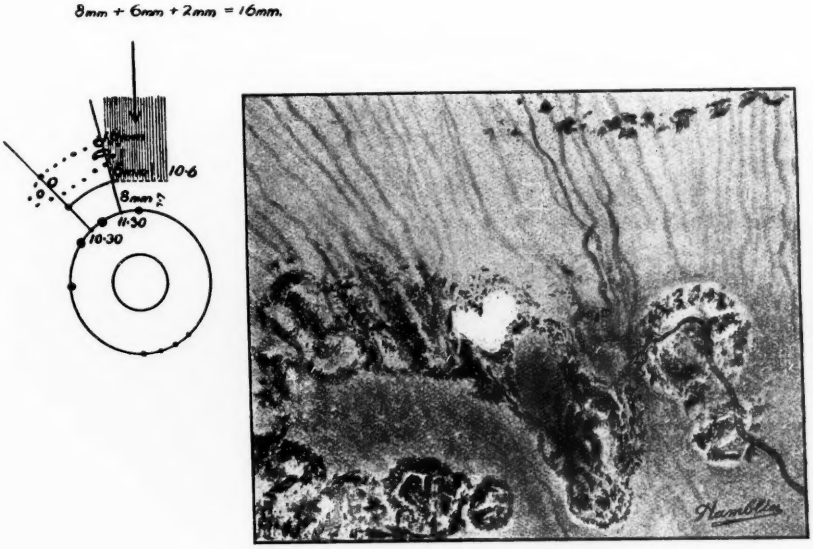
I feel one should also mention the wonderful amount of work done by Prof. Sourdille, of Nantes, who worked coincidentally with Gonin. Sourdille's conception of the causation of detachment of the retina was different from that of Gonin. He believed that degeneration started in the choroidal layer; subsequently fluid formed, which finally caused a rupture of the retinal layer. His treatment consisted of multiple punctures with a long, thin Graefe, the puncture going through the detached retina into the vitreous. At the entrance to the punctures he injected 1:1000 cyanide of mercury under the conjunctiva, this fluid causing an adhesive choroiditis. Sourdille also made use of fine electro-cautery needles, with which he made multiple punctures in the region of shallow detachments.

In 1932 Sven Larsson, of Sweden, wrote a paper on the treatment of detachment of the retina with diathermy. He used a small ball ·65 mm. in diameter; this was held against the sclerotic for five seconds with a weak current of about 50 milliamperes. This application caused small areas of coagulation in the choroid, which caused the retina to adhere. When the cauterizations were finished, a trephining was done to let out the subretinal fluid. Larsson claimed that his operation caused far less danger to the vitreous, and one could ignore the importance of the hole in the retina, as by the large areas of coagulation the whole detached retina could be made to adhere.

The next important communication was that of Prof. Weve, of Utretcht, who published a paper on the treatment of detachment of the retina by diathermy. He especially supported the work of Larsson, but went still further, and in some cases used a fine, straight needle, with which he made multiple punctures *into the sclerotic*, a third of its depth; if necessary he made a

further puncture with a larger diathermy needle to let out the subretinal fluid.

At the same time that Weve was working with his fine needle, multiple puncture operation, Dr. Safar, of Vienna, had patented a special instrument with several needles, $1\frac{1}{2}$ mm. long, which are at right angles to the handle, with which he perforated the sclerotic and got areas of coagulation situated in the choroidal layer, these areas being about the size of the optic disc. In Safar's operation no trephining or subsequent punctures are made, as the needle punctures allow the subretinal fluid to come out and continue to drain into the subtenon capsular space. The special arrangement of the needles allows the operator to make punctures right back to the posterior pole of the globe.



RETINA AFTER SAFAR'S OPERATION.

I propose now to give short accounts of two operations, first Gonin's, and then the operation perfected by Safar.

I have chosen these two operations because I feel they are the most important. Gonin was the first man to publish a large group of cured detached retina cases, and his technique has been very closely followed by all operators, whatever their method, the one exception being Larrson—who does not bother about the closing, or surrounding, of the tear.

GONIN'S OPERATION.

Gonin is especially keen on a very careful examination of the case as regards local symptoms, the field, or lack of field, of vision, any blind spot or local disturbances, such as floating objects, flashes of light, etc. All these points help to show in what region to look principally for the tear. Searching for the tear is a very important point. Gonin works in the various diameters of a clock-face, and notes different areas where there are pigmentary disturbances and fine, degenerative patches. In his papers Prof. Vogt especially laid stress on the importance of degenerative patches other than pigmented ones.

When the tear has been found Gonin makes most minute and careful sketches of the tear and its surrounding structures. Then he carefully marks out the position of the tear on the sclerotic. He leads up to this point by first making marks at the limbus, and getting the exact diameter of the clock on which the tear lies. He finds the meridian of the tear by measuring in disc diameters the distance from the ora serrata, the portion of the retina which is, on an average, 8·5 mm. from the limbus.

The final step is done after he has given a subconjunctival injection and made the field of operation quite anæsthetized. After making the necessary conjunctival incision and exposing the sclera, he plunges the cautery —at a white heat—through the sclerotic to the depth of about 4–5 mm. The cautery passes through the sclera, choroid and retina into the vitreous.

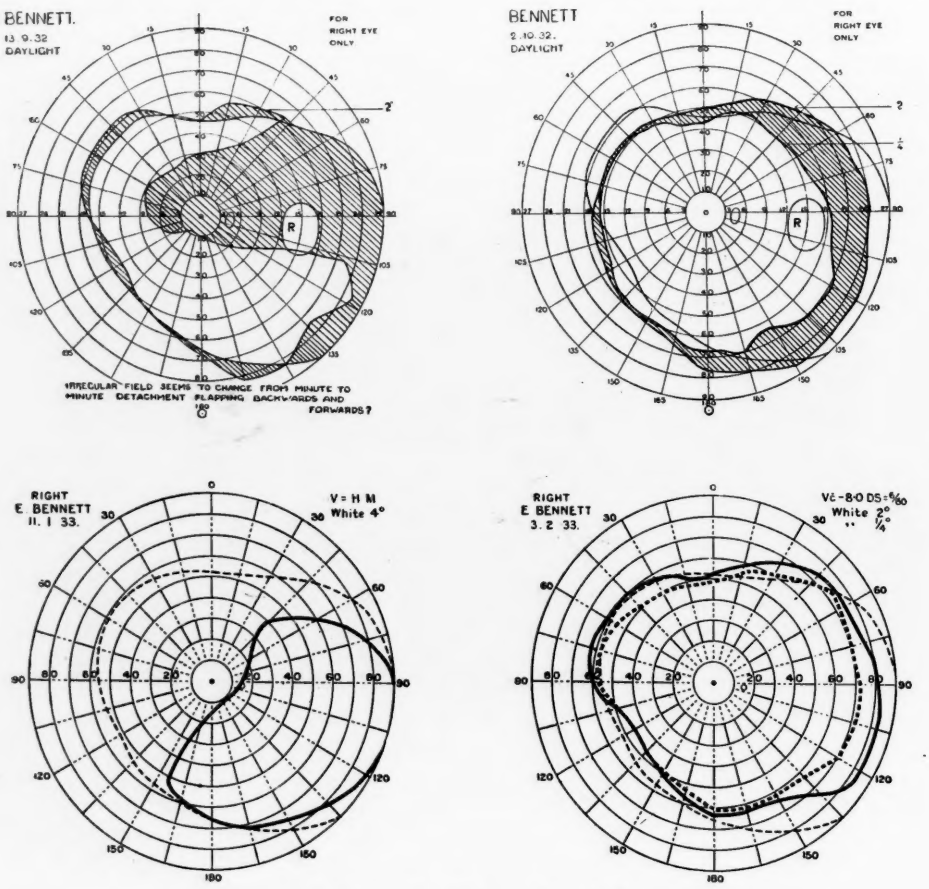
Immediately the cautery is taken out, he ties the suture, which he had previously placed on the edge of the conjunctival incision, and the patient is put back to bed in such a position that the vitreous presses on the situation of the tear. If no complications arise the eye

is dressed on the third or fourth day after the operation and a very rough test is made with hand-movements. At the end of a week a further examination is made, and if the retina is back the patient is allowed to get up on the fourteenth day. If the case is not cured Gonin operates again in two or three weeks.

The following illustration shows a case cured by Gonin's method. The patient was admitted to the

SAFAR'S OPERATION.

I now propose to describe the operation evolved by Safar, which, up to the present time, I consider to be the best surgical treatment for detachment of the retina. The method consists of making many punctures with a short, specially isolated needle, which is attached to the active pole of a special diathermy apparatus, with which



VISUAL FIELDS BEFORE AND AFTER SAFAR'S OPERATION.

Western Ophthalmic Hospital on September 8th, 1932. He had first noticed that he could not see to read a paper with the right eye after playing tennis. His vision gradually became worse, until he could only see hand-movements; the field was greatly reduced in size. A tear was found to be situated under the internal rectus of the right eye, 14 mm. from the limbus. Fortunately it was possible to close the tear with one puncture, and the patient, who has $\frac{6}{12}$ vision and a full field, has been back at his work for over twelve months.

one can work with a very low milliamperage. Safar's needles are about $1\frac{1}{2}$ mm. long, and are at right angles to a carefully isolated handle, which is inserted into a holder attached to the diathermy machine by a long cable. It is important that whatever machine is used it should be so constructed that there is no sparking; the current can be regulated minutely and the milliamperage used easily seen. Safar uses many kinds of points, but a great deal can be done with the one-point needle. On the other hand, "nails" have been

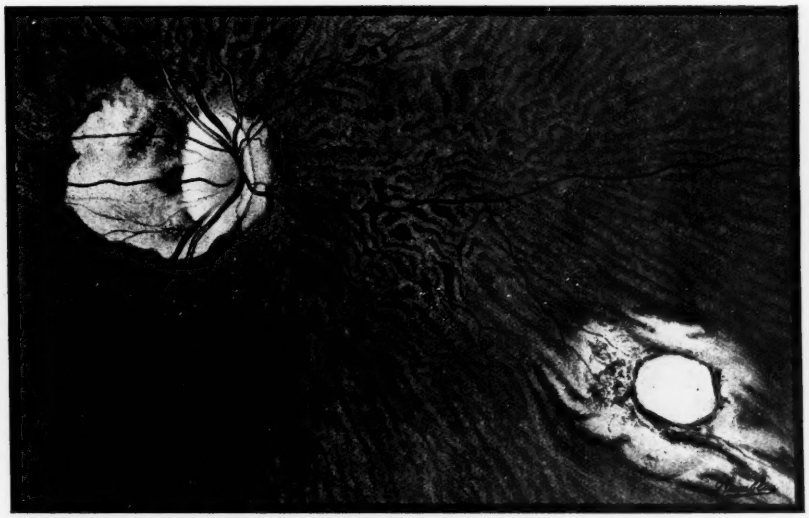
constructed with three points, 2 mm. apart, which can be inserted under current into the sclerotic, and left *in sitû* until the required number of punctures has been made. By this method it is possible to keep the globe at a good tension. For tears more than 16 mm. from the limbus, either the one-point needle, or a special handle with round or oblong plates at the end, into which six or nine needle points are inserted, at right angles, can be used. If the latter is used it is important to draw it out " under current ".

The first stages of Safar's operation are the same as Gonin's, except that it is not so important actually to mark the exact site of the tear, as this can be encircled by the multiple punctures; or a tear within 16 mm. of the ora serrata can be partially encircled with punctures, the base of the semicircle resting on the ora serrata line. An important point is to get the sclera very clean and free from subtenon capsular adhesions. If necessary muscles can be resected in order to get large areas exposed; half, or more, of the circumference of the globe can be laid bare without danger, though it is best to avoid resecting more than two muscles.

With Safar's method there is no restriction to the treatment of tears, however far back they may be situated, but when the tear is posterior the position of the venæ vorticosæ veins must be remembered and avoided; the punctures should be made posteriorly to where they make their exit from the sclera, and also at the sides of the point of exit, and not right through the sclerotic. When making the punctures it is important to place the point of the needle in the sclera before applying the current.

The punctures should be posterior to, or free of, the margin of the tear or " disinsertion " tears treated. This enables the healthy, untouched retina to adhere to the areas of coagulation which are situated in the choroidal layer.

The most important points of Safar's technique are that he does not injure the retina or enter the vitreous, and that the subretinal fluid drains off slowly and continually through the diathermy punctures, thus doing away with the trephinings or punctures which are necessary in Larsson's method. These trephinings, etc., may cause a " hernia of the choroidal tissue " and, eventually, dragging on the retina and subsequent retinal bands or fresh tears may be formed. The scars formed with Safar's method are so placed that retinal vessels can be seen passing flatly over them.



RETINA ONE MONTH AFTER SAFAR'S OPERATION.

To obtain successful results one should try to keep the patient in bed for at least three weeks, and, if possible, the patient should lead a very quiet life and lie up as much as possible for another five weeks. Also, after the first fortnight it is beneficial for the patient to use a special pair of dark spectacles, made of celluloid, with a hole 5 mm. in diameter in the centre; these are called Lochbrille glasses. An efficient glass of this kind can be made by putting dark paper, with a central opening, on an ordinary pair of spectacles.

The illustrations show a successful operation carried out according to this technique. The holes were

marked out and surrounded by 16 to 20 diathermy punctures. The man, a tailor, æt. 58, only saw daylight on January 5th, 1933. After the operation he saw $\frac{6}{18}$ with his proper correction. On November 3rd, after working at his trade since March, he saw $\frac{6}{18}$. The area of the punctures is now much whiter and less injected than in the illustration, which was done a month after the operation.

Since this operation many successes have been obtained by my colleagues, and some cases have been most striking in that they have showed the immense area which can be treated, and that tears of more than a year's duration can be successfully treated. The method has been successfully carried out in detachments which have occurred after the needling of a congenital cataract, or after the needling subsequent to the removal of a senile cataract. It also appears to be the best method so far evolved for the treatment of extensive detachments in which no tear can be found.

REFERENCES.

ARRUGA.—*Arch. de Oftal., Hisp.-Amer.*, October, 1929.

GONIN, J.—"Les résultats de la thermoponction oblitérante des déchirures rétiniennes," *Ann. d'Oculist.*, September, 1931, pp. 681, 689; *Arch. d'Opht.*, November, 1930, iv, pp. 621–625; *Rev. Gén. d'Opht.*, 1929, xliii.

RUBBRECHT, J. J.—"Action des substances irritantes sur la choroide et sur la rétine," *Soc. Belge d'Opht.*, 1931.

SOURDILLE, G.—"Une méthode de traitement du décollement de la rétine," *Arch. d'Opht.*, 1923, xl, p. 419.

LINDNER, K.—"Ein Beiträg zur Entstehung und Behandlung der idiopathischen und der traumatischen Netzhautabhebung," *Arch. f. Ophth.*, 1931, pp. 127, 205, and 264.

GUIST, G.—"Eine neue Ablationoperation," *Zeit. f. Augenh.*, 1931, lxxiv, p. 232.

WEVE, H. J. M.—*Zur Behandlung der Netzhautablösung mittels Diathermie*, Berlin, S. Karger, 1932; *Nederl. Tijdschr. v. Geneesk.*, 1930, lxxiv, p. 2354.

LARSSON, SVEN.—"Operativ Behandlung von Netzhautabhebung mit Elektroendothermie und Trepanation," *Acta Ophth.*, 1930, viii, p. 172.

SAFAR, K.—"Discussionsbemerkung zu Sallman," *Zeit. f. Augenh.*, 1932, lxxvii, p. 126.

Idem.—Behandlung der Netzhautabhebung mit multipler diathermischer Stichelung, S. Karger, Berlin, 1933.

VOGT, A.—"Zur Heilung der Netzhautablösung mittels Ignipunktur des Netzhautrisses," *Klin. Monats. f. Augenh.*, May, 1929, lxxxii,; "Weitere Erfahrungen mit Ignipunktur des Netzhautloches bei Netzhautablösung", *Klin. Monats. f. Augenh.*, March, 1930, lxxxii.

J. COLE MARSHALL.

SPLENECTOMY FOR ESSENTIAL PURPURA HÆMORRHAGICA.

(ESSENTIAL THROMBOCYTOPENIC PURPURA HÆMORRHAGICA.)

PURPURA is usually divided into (A) primary and (B) secondary. The primary is subdivided into (1) hæmorrhagic purpura (purpura simplex, purpura hæmorrhagica and purpura fulminans); and (2) anaphylactoid purpura (Henoch's purpura and Schönlein's purpura). In this article we are dealing only with essential purpura hæmorrhagica.

In essential purpura hæmorrhagica, in addition to the presence of purpuric spots on the skin and mucous membranes, there is bleeding from one or more mucous membranes, such as the nose, mouth, gums, urinary tract, uterus, intestinal tract, etc. It is the experience of most physicians who have investigated this disease that certain tests give with it positive results which clinch the diagnosis. These tests are: The presence of thrombocytopenia (the platelets being reduced at some period in the history of the case to 40,000 or less, and not infrequently none may be seen for a time); increased bleeding time from the normal 3 to 4 minutes to perhaps 15, 30 up to 60 minutes or even longer; and a positive capillary resistance test (*i.e.* if a pressure midway between the systolic and diastolic be maintained on the upper arm either by a rubber bandage or blood-pressure instrument for 3 minutes, hæmorrhagic areas appear, in positive cases, between the lower end of the bandage and the wrist). A flat-topped blood-clot has been described in this disease, but I do not think that this is of any real value, as many other diseases show the same thing.

I would suggest that the presence of the above clinical picture and positive tests signify the presence of this type of purpura. It is interesting to note that the blood coagulation in these cases is practically normal in contrast to what obtains in hæmophilia.

Purpura hæmorrhagica can be a very serious complaint from the anæmia, etc., resulting, and it occasionally proves fatal from severe loss of blood when not adequately treated.

Hess suggested and Kaznelson first carried out treatment by splenectomy. There have been a good number of operations performed for these cases to date, but unfortunately all observers do not record equally successful results such as follow splenectomy for splenic anæmia, acholuric jaundice, certain cases of Gaucher's disease, Henoch's purpura, etc.

Acute, intermittent and chronic forms of essential purpura hæmorrhagica are described, and it is usually alleged that the chronic form is specially suited for splenectomy, but in my experience this operation can be performed with confidence in any of these forms providing a correct diagnosis of the condition has been made.

The only other treatment, so far as I have seen, which has proved useful is blood transfusion, but the good effect of stopping hæmorrhages only lasts for a few weeks.

I have had five cases of essential purpura hæmorrhagica, all of which were severe, and splenectomy was performed in each case by Mr. Rodney Maingot. The following are brief details:

(1) Mrs. D—, at present æt. 37, first suffered from purpura at the age of 14 years. From time to time the symptoms recurred until about nine years ago, when, after a miscarriage, she suffered from a severe uterine hæmorrhage which the gynæcologists were quite unable to control. She had an extensive purpuric rash on the skin and an appreciable crop in the mouth. Slight oozing was taking place from the gums. The temperature was 104° F.; she had sighing respiration, and the red blood-corpuscles numbered only 2,000,000. The thrombocytes were nearly absent. The capillary resistance test was positive in a marked degree in 2 minutes. The bleeding time was 15 minutes. All the usual styptics were unavailing, and she was given a quarter of 1% citrated blood transfusion. Within a few hours the hæmorrhage began to cease and had completely stopped by the next day. She made a complete recovery in a few weeks and left hospital in good health. After about two months symptoms recurred, and not wishing to take any further risk I asked Mr. Maingot to do splenectomy. Although nearly eight years ago there has been no further attack of purpura, no hæmorrhages of any kind, even after the extraction of teeth, and menstruation, which was the bugbear of her life previous to operation, frequently necessitating her admission to hospital, became normal and remained so. She looks at present the picture of health. It is interesting to note that the capillary resistance test has remained negative since splenectomy, and the bleeding time is also normal, while the platelets increased to nearly 200,000 within a few days of operation. The last blood examination performed a few months ago showed: Red blood-cells, 4,800,000, hæmoglobin, 87%; colour index, 0·89; white blood-cells, 9000. Differential count: Polymorphonuclears, 64%; eosinophils, 2%; basophils, 1%; large hyalines, 7%; lymphocytes, 26%. The red blood-corpuscles showed no significant abnormality. The platelets were 194,000 per c.mm. Clotting time normal—$3\frac{3}{4}$ minutes; bleeding time normal—$3\frac{1}{2}$ minutes. Capillary resistance test negative.

(2) Winifred B—, æt. 19, suffered from her first attack of purpura at the age of 10 years. When admitted to hospital she was suffering from continuous oozing from the gums (this had been present for two months), and purpuric spots on the skin and mucous membrane of the mouth. The platelets were almost absent, the bleeding time 20 minutes and the capillary resistance test positive. All attempts to stop the oozing failed, and splenectomy was accordingly performed some eight years ago. During anæsthesia the anæsthetist was anxious on account of the continuous oozing from the mouth, but a curious thing was observed by four of us: Very soon after the splenic vessels were tied, oozing ceased from the gums. She made a perfect recovery, and has had no purpuric symptoms since, and at present is in robust health. Menstruation has become normally established. Since operation the bleeding time has been between 2 and 4 minutes, which is normal, and the capillary resistance test negative. The last blood-count was as follows: Red blood-cells, 4,650,000 per c.mm.; hæmoglobin, 79%; colour index, 0·84; white blood-cells, 6700 (the differential count being polymorphs 51%, eosinophils 2%, basophils 1%, large hyalines 10%, lymphocytes 36%). The red blood-cells showed mild anisocytosis and a few were pale. The platelet count numbered 110,000 per c.mm. The clotting time was normal—$4\frac{1}{2}$ minutes—and the bleeding time $5\frac{1}{2}$ minutes.

(3) Joyce M—, æt. 9, suffered in July, 1931, from purpuric rash on the skin and the mucous membrane of the mouth; continuous oozing took place from the gums and nostrils. The capillary resistance test was positive; the bleeding time $1\frac{1}{2}$ hours; the platelet count being 16,000 per c.mm. From my previous experience of a similar case I decided to have splenectomy done. This was followed by cessation of bleeding from the gums within a few minutes of the splenic vessels being tied, similar to Case 2. This child is still in perfect health, and has had no further attacks of purpura. Tonsillectomy was performed nearly two years ago, when only slight bleeding occurred. The last blood examination showed: Red blood-cells, 4,500,000 per c.mm.; hæmoglobin, 80%; colour index, 0·89; white blood-cells, 8800 (the differential count showing polymorphonuclears 68%, eosinophils 2%, basophils 1%, large hyalines 6%, lymphocytes 23%). The red cells showed no significant abnormality, and no abnormal whites were seen. The platelets numbered 270,000. The clotting time was normal and the bleeding time 3 minutes. The capillary resistance test was quite negative.

(4) A. W—, boy, æt. 6, suffered from bleeding from

the mouth and bowel with cutaneous and subcutaneous purpuric hæmorrhages. The platelets were practically absent (Dr. Knyvett Gordon). The spleen was not enlarged. The capillary resistance test was positive. Splenectomy was performed, and I am informed that this boy, after nearly eight years, remains in excellent health and free from purpura.

(5) Edith W—, æt. 10, was under the care of my colleague, Dr. H. Dunlop, who kindly asked me to see her with him about nine months ago. For nearly twelve months previously she had suffered from purpuric spots on the skin. A few large purpuric spots were seen on the lips, inside the mouth and on the hard palate, and blood oozed freely from them. Similar spots were found later on on the tongue. Epistaxis became troublesome. The platelet count was 28,000. She developed nervous symptoms, with paralysis of the muscles of the right eye, the pupil being completely paralysed. There was weakness of convergence and incomplete ptosis. The lower part of the left side of the face became weak, and also the left arm; the latter was ataxic. Left plantar reflex was indefinitely extensor, the right being flexor. All cleared up completely, the right eye being the last to do so and the pupil last of all. We looked upon the cause as being probably a slight purpuric hæmorrhage in the brain. Although the paralysis completely cleared up and her mentality remained perfectly normal, the bleeding continued from the nose, lips and mouth, and fresh crops were apparent on the skin. Blood transfusion was performed and improved the condition for about three to four weeks, during which time there was no bleeding from the mucous membranes, but the platelet count, which was 20,000 before transfusion, remained at about the same figure afterwards. Splenectomy was performed nearly four months ago. No further attack of purpura has happened since, and she has remained in excellent health. After splenectomy the platelet count went up to 400,000, the figure immediately before operation being 28,000.

It is interesting to note in this child that the capillary resistance test was negative until just before the operation, when it became slightly but definitely positive; the bleeding time increased from 7 to 15 minutes. The capillary resistance test is now negative and the bleeding time normal.

Commenting on these five cases, it is noted that each suffered severely from bleeding from the mucous membranes. In none of the cases was the spleen enlarged clinically, and all the spleens were found normal in size at operation. Each case was in a serious condition before operation, and each patient has so far remained in perfect health since splenectomy was performed. In every instance Mr. Maingot looked for accessory spleens, and when found removed them. I would suggest that medical men who have had splenectomy performed on a patient for this type of purpura and seen recurrences after six to twelve months, or thereabouts, did not look for accessory spleens. If such be present and not removed it would presumably grow to full size in about a year. Any case which shows signs of recurrence after splenectomy would, I think, merit a laparotomy to ascertain if accessory spleens be present. If found they should certainly be removed. Recently, at the Clinical Section at the Royal Society of Medicine, a speaker stated that he had removed a spleen for acholuric jaundice, but symptoms recurred after about a year. On reopening the abdomen he found an accessory spleen had grown to full size. This was removed and the symptoms disappeared.

In several of our cases during operation Dr. Knyvett Gordon took samples of blood from the splenic artery and the splenic vein; the former numbered in one case 168,000 platelets and the latter 56,000. This is very interesting, and just what would be expected.

It is apparent that bleeding from the nose, mouth, urinary tract, gastro-intestinal tract, uterus, etc., may in certain cases be due to purpura, and this should always be kept in mind.

It seems to me that the cause of essential purpura hæmorrhagica is probably due to the presence of a toxic substance in the spleen in these cases, which, through the blood-stream, so affects the endothelium of the capillaries that oozing of blood takes place. It is interesting to note that after splenectomy in these patients, when no accessory spleen is left in the abdomen, this does not happen, therefore the fault must be primarily in the spleen and not in the capillaries. There seems to be a definite relationship between urticaria, purpura hæmorrhagica and anaphylactoid purpura.

A word of warning should be given before suggesting splenectomy for purpura hæmorrhagica. The clinical history, symptoms, signs and the tests which have been mentioned should all be carefully weighed before determining on operation. Whereas splenectomy is probably the real treatment of a definite case of essential purpura hæmorrhagica, it would be most unfortunate if a spleen were extirpated for the wrong type of case, and I have known two cases of unusual types of leukæmia, thought to be purpura, in which splenectomy was performed, with quickly fatal results.

BERNARD MYERS.

SURGICAL APHORISMS.

(*Continued from p. 29.*)

59.

The surgeon who aspires to success in gall-bladder surgery will not be content with having made a diagnosis. He must carry to the operation a knowledge of every detail of the patient's history, signs and symptoms.

60.

Lord Moynihan has observed that operations on the gall-bladder and bile-passages are done by the left hand of the assistant. But even with a clear view disaster will occur unless the meticulous isolation of every structure concerned is made an absolute rule.

61.

A clamp on the common bile-duct, an injured hepatic artery, are surgical crimes which hardly admit of extenuation.

62.

Extreme statements have been made as to the necessity, or the reverse, for the open exploration of the common bile-duct to determine the presence or absence of a stone. But here, if anywhere, is a situation demanding the exercise of judgment at the expense of routine.

63.

If the common bile-duct is opened it should be drained —a course which has no dangers and several advantages.

64.

Acute cholecystitis presents very much the same problems as acute appendicitis. But it is less likely to result in suppuration, and the case against immediate operation is heavily weighted by the immensely greater technical difficulty and the consequently greater risk in average hands.

65.

Numerous are the conditions unconnected with the appendix which produce a more or less complete picture of acute appendicitis. The surgeon who is too much preoccupied with eliminating these will sometimes fail in diagnosing a genuine case.

Better remove some normal appendixes than inadvertently join the waiting school.

66.

The retro-cæcal appendix is sometimes the occasion of a fall into this pit. It grows inordinately long, so that the local signs are found high in the flank or below the costal margin. Its position ensures that there shall be slight local peritonitis, and therefore little rigidity. Awareness of the possibilities is the key to diagnosis.

67.

A persistent fæcal fistula after drainage of an " appendix abscess " is more likely to be due to an undiagnosed carcinoma of the cæcum than anything else. Full investigation is, therefore, always essential.

68.

Generations of teachers have dinned into generations of students the importance of a rectal examination in diagnosis. Yet a reluctance to do it inexplicably and universally persists. Perhaps cultivation of the habit of carrying finger stalls in the waistcoat pocket would effect the necessary change of mind.

GEOFFREY KEYNES.

(*To be continued.*)

CIRCA 1877.

THE other day Prof. G. E. Gask was kindly advising me as to the care of this vile body which my spirit carries round with me. We talked of a journal I have written as to my first five years in India, and he asked if I had any reminiscences of Bart.'s. Now my journal was based on a series of letters I had written for five years from 1880 onwards, and I have no letters *re* Bart.'s, worse luck. I must stir up my memory.

Memory functions very weirdly. I believe that every event, even the most trivial in our lives, is registered in our brain-cells, but subconsciously. Adopting modern theory we may hold we are interpenetrated by that steel-like elusive factor, the ether. Does this register as well ? Or are these brain-cells forms of ether ? Whatever the registering factor may be I entertain no doubt that it makes a continuous subconscious record, passed on from old cell to new cell, and that when the cells are stimulated, long-forgotten thoughts emerge from latent vibrations.

This speculation upon the action of the unconscious mind leads my thoughts first to a practical issue. Were I to be trained again in the wide realm of professional knowledge dealt with at Bart.'s I would ask to be allowed into the wards from my earliest days. This for three

reasons. One is that these subconscious memories keep working productively. Another is that clinical experience is the most valuable asset a man can have. The third is that in my conception of training I would see a case first when entirely ignorant, and then read the anatomy, physiology and argument as to treatment. I believe I would learn twice as fast, more thoroughly in the end, and certainly in a more interested way *en route*. I know the arguments *contra*: I merely express my own feeling. My views are rank heresy to-day, but may not be so to-morrow. The system is, in fact, a reversion to the old apprentice days. The underlying error of to-day is that parents do not decide early enough upon the career of their sons—too intricate a proposition for me to enlarge upon here.

After all I have had considerable experience in how to learn—I had eight strenuous years. About 1873 I went to the Queen's College in Cork—part of the old Queen's University of Ireland—and there took degrees in Science. But what next? My old professors pointed out I was half-way through Medicine. I was then captain of the XV and of the cricket XI, and it was decided I should transfer the energy involved to Bart.'s. So in 1877 I crossed the stormy seas, and feeling very ill indeed (as I had then the ancient notion of fighting the sea instead of being comfortably sick), I presented myself to Norman Moore, then Dean, upon my arrival at midnight. That worthy man came down in a dressing-gown and long furred Russian boots—a picture I have always retained—and gave me a bed and a dose of calomel. I got rooms in Islington, the College being full. Sir Norman (as he became) took me for walks more than once through the back lanes and side streets, while he discoursed upon their history. Every man at Bart.'s should know the stories of these lanes, each bit of English history, back to 1123.

Of that date, 1123, I have a curious record. When P.M.O. under Sir John Maxwell in Egypt in 1911 I went on inspection duty to Cyprus. Duty completed, a friend and I set off on mules across the island to visit the old Greek Monastery of Kykko, which we reached after a day's riding. We found a walled fortress, and therein were made welcome and a room given us and a dinner, after which the abbot came to see his guests. He wore a long-buttoned soutane and a tall hat with the brim in the wrong place, and a long grey beard. We talked in a mixture of French, Greek and Arabic. "Of course," he said, "you English cannot speak correct Greek, as you learned it 400 years ago from old Erasmus, who was never in the country!" And the point of this digression is that I saw carved over the gateway the date of Bart.'s—1123. I may add that I think no man can use the English language thoroughly and correctly unless he has some knowledge of Greek and Latin. We scientific people quite grasp the force of this view, even if others do not.

Now I get back to Bart.'s again. I was tried as a full back and later on was established in the 1st XV (we had three teams)—not altogether a pleasant position, as sometimes one had little to do, but that little had to be perfect.

I always held that drop-kicking at goal should be frequent. Few agreed with me then, but nowadays I see the practice is being cracked up. It is a quick bid for victory, but when near the goal the kick should be high and followed up smartly, as in case of a miss a touch-down is still on the cards. Forwards argued that their work was thrown away, but it was nearer the truth to say they could not drop-kick. Against a resolute back-line defence it is often the only chance of a win. In Ireland I chose "quarter-back" or "half back"—the old terms—as my post, and sometimes snatched a win with a drop kick. In '77 the United Hospitals in London had a splendid team, and I have seen even the full back (? Christopherson) making these shots—a lovely sight.

That brain we have been considering is a queer old thing in its way. One of our half-backs was Little (later Colonel I.M.S.), and one day he was discovered playing a very fine game, but against his own side. He had had a partial knock-out. I had a somewhat similar experience. In those days we had a "maul in goal"—behind the goal posts. An enemy and I fought like fury for full possession of the ball, while the rest of the two teams stood round. I defeated my enemy—a Wasp, I think—but I somehow got hurt without knowing it, and soon after, the game ended. In the dressing-room, a quarter of an hour after the maul, I stood up and cried out, "Where am I?" Then came Taylor, our captain, to soothe me, but I struck him. However, I was put under the cold-water tap and got home all right. For a week I felt ill, and then was violently sick, and so the matter ended. No one in those days troubled much about the physiology of such incidents. Perhaps we were more hardy fellows—being nearer to primeval man.

Bart.'s wore black jerseys with a shield of the arms stitched to the left breast, and, the shield being of wire and often frayed, we eroded the faces of our enemies, who became full of wrath thereat, and at times used shocking language! Our team looked very small in black, but black demons they proved in conflict. I presume this form of shield had soon to be scrapped.

I still possess an old football card of 1877–78. Here are the names thereon: President, R. Wharry, Esq., M.D.; Vice-Presidents, H. T.W. Blakeney, A. H. Burlton; Captain, W. C. E. Taylor; Vice-Captain, E. T. Power;

Captain, 2nd XV, G. H. Barling; Hon. Secs., C. P. Hooker, W. Outhwaite. Committee, R. Gill, W. A. Sykes, T. Kirsopp, J. Little, E. P. Clarke, F. H. Treherne, W. Gripper, J. E Square. The fixtures included matches against Arabs, Flamingoes, Wasps, Harlequins, Vampires, Gipsies, St. George's, Guy's, King's, Royal Military College, Royal Naval College, etc.

One day Norman Moore took me to task for not attending lectures. I explained I always put in the required number, and then added—philosophically, not rudely—that I found I got more value from reading. He became thoughtful. In after years my ideas clarified as to how to get the best value from a lecturer, and I imparted these ideas lately to two of my young friends, one at Bart.'s, the other at Guy's. The best plan is to read ahead of the lecturer, and one may add the lecturer would always do well to announce the subject of his next. He does so sometimes. Then the student can sit listening carefully, making but a few notes, and only of what the lecturer stresses. Long ago I and my friends at Bart.'s used to make volumes of notes, and then find, after shocking fag, that the whole matter was in print. I had one quite useful tip I invented in my science studies. Take a piece of foolscap and fold in many folds like a concertina. In each column, say one column to one chapter, enter the important points. In the end you have the whole subject in a bird's-eye view. You run over it in half the time. You see correlating points. Even to-day I use this concertina system in other matters.

I worked as post-mortem clerk under Wickham Legg. He always looked very smart, wearing a wide black silk cravat, and showing a fine set of white teeth, arranged in a dazzling smile. Bart.'s colours, of course—black and white. One day it fell to me to examine a suicide. This poor devil had jumped from the Whispering Gallery in St. Paul's—then not protected as it is to-day—and had struck on a chair, one of the uprights passing through his chest. But the strange thing about it was that on contiguous sides of the chair which he struck were seated two old ladies. He smashed in between them. Imagine their horror!

A man I had a special affection for was Morant Baker—a big, pleasant, genial man. I connect him in my mind with physiology, and also with a book on that entrancing subject that I was very fond of. I had it "paved"—*i. e.* underlined—carefully, and could get through it in some eight hours. I recall starting at 10 p.m. and finishing at dawn. Such action was, of course, in consonance with my ideas and methods of trying to envisage a complete view of any subject.

Now for a word on surgery. In Cork I had already been baptized. I went one day to the South Infirmary to sample the procedures. Dr. Tanner—as he was termed, though a surgeon—habited in a very blood-stained old black coat, was talking to a stalwart farmer. Then seizing the man's lower lip in his left hand, the patient standing bolt upright, Tanner inserted a knife near the chin and cut out through the lip. Following this with another similar cut, he removed a V-shaped piece. I was standing packed in with other students and found hat and books on the floor, so I concluded I had had a shock. But think of the courage of the farmer! Next day we all went to the operation theatre, and Dr. Tanner was again at work. He wanted extra help, and looking up caught my eye and called me. My God! I thought, but pulled myself together. I had need to, as Tanner was removing a woman's breast. But I stuck it out and never had qualms after this truly bloody experience.

One morning at Bart.'s some visitors of much distinction were in the sacred ring in the theatre. A polite Frenchman was introduced to Mr. Smith. "Oh," quoth the Frenchman, "I do know de name of Smit!" "That is Smith of London," said our man; "I am Tom Smith." There was much joy in the back benches over this. White coats were then coming into use. I remember clouds of carbolic spray. And I also visualize chloroform being simply shaken from a bottle over a bit of lint held a little way off the face.

Anæsthetics bring to mind a curious method of revival in a far-off land. In the hot weather at Hyderabad in Sind I used to pass the time assisting on old officer of the I.M.S. to crush for stone—his hobby. One day a little child stopped breathing. "Now watch," he said, and he thrust his finger up the anus, rooted about, stirring the sacral plexus, and the creature gasped and came round. He smiled triumphantly and said the method was infallible. A tip for our anæsthetists!

How splendid it would be if we could see into the human body with eyes like X-rays. On Lake Como I heard a story of a peasant watching a surgeon looking for a bullet in 1870. The peasant said he *saw* it just there and just there 'twas found. It is added that this man's unusual power, akin to that of the water diviner, was often utilized. If tentative examinations were made with the eyes shut would tactile sense increase? The fingers of the blind become very sensitive.

I played no cricket at Bart.'s, although in the XI in co. Cork, but to watch cricket at Lord's was a great joy, in days when the 'Varsities set the model in fielding. Two articles of mine—on "Timing", which I define as "the exact co-ordination of two fine adjustments", and upon "Fielding"—appeared of late years in the *Cricketer*. I commend them to our team at Bart.'s. In those days we had a fives court. Turn to the left as you come in the archway near the Great Hall. Here

we smote the ball with gloved hands—or without the gloves.

I was clinical clerk to Reginald Southey. I had charge of a child with diphtheria, and when he asked me some question as to the strength of the lotion used to swab the throat, I put my finger in the bowl to taste it and test it. He struck my hand away and let me have it. Just thoughtlessness; I really knew better. Then we had a case with a pustular eruption, and for half an hour were shown it could not possibly be other than chickenpox. So we went off knowing all about it. Three days later it was smallpox right enough. And there was cynical laughter among us wiseacres. We did not then know the adage that the best surgeon (or physician) is not the man who makes no mistakes, but the man who makes fewest.

Midwifery I studied under the imposing personality of Matthews Duncan, and saw the total cases required then (? ten) in those back lanes we wot of. Nothing unusual happened. It came to pass some twenty years after that I found myself professionally alone on a hill-top in India, to which all the ladies who loved their lords had come. I think those six months added lines to my face that have never been eradicated. Realizing my ill-fortune, I collected books and instruments, and daily went through operations in my room, as if actually in touch with a patient. Every case proved difficult except one. Meeting this lady's husband a month later, when I felt sure all was well, he gave me one of those shocks that remain engraved on the mind. She had died suddenly.* Here I venture to indicate what should be the aim of every student. Never go into practice of any kind until you have held the posts of H.P. and H.S., as in the serene and comfortable atmosphere of the New Surgical Block. And if not there, then elsewhere. The motto of Bart.'s—the old Horatian tag—as to keeping your head when in a fix—is very well indeed. But even better is full confidence that you do know your job.

I have just fished out some certificates that have been lying hidden for years, and it seems appropriate to quote them. While working at Bart.'s I was still applying for divers chairs—in Natural History, Geology, Botany, etc. Here are recommendations from my older teachers, including William K. Sullivan and Robert Cunningham, well-known scientists of the 'seventies. But here, too, are gracious recommendations from my good-natured teachers at Bart.'s. Reginald Southey—to whom I was clinical clerk—praises my spirit of inquiry. Did he recall the diphtheria incident? At any rate he gives me three pages—decent man—and adds a private note equally kindly. Norman Moore, Lecturer on Comparative Anatomy, writes in his curious script. W. Morant Baker, Lecturer in Physiology and Assistant Surgeon, deposes to my work as his dresser. A. E. Cumberbatch, Senior Demonstrator in Anatomy, Wickham Legg, W. J. Walsham, Demonstrator in Anatomy and Operative Surgery, sign other letters. The latter says he had the good fortune to be one of my teachers—Heaven forgive him! Clement Godson, M.D., Assistant Accoucheur, adds a word. In reading these generous efforts to help me, I recall all these men of the past; their anxiety to turn out good men from Bart.'s, and to help them onwards. For many centuries Bart.'s has had its noble river of fine teachers, one wave after another, and I am glad to recall in detail the particular wave upon which I had the good fortune to be borne.

As my memory wakens, other faces appear. Sir James Paget visited us occasionally, his features suggestive of a bishop mourning over the spiritual sins of his people, and, as a contrast, Lauder Brunton, smiling in his brown beard as who should say, "I've eaten the canary"; Luther Holden, thin and kindly, and sporting Dundreary whiskers; Church, tall, like a steeple; Thomas Smith, looking tired. The stern Savory rather frightened us. In his opposition to Lister we have an example of ideas in consonance in striving for perfection, but antagonistic in detail. In those days surgery merely nodded to bacteriology, and both then and later men worked in closed compartments; but now every day we realize more and more that the Science of St. Luke—viewed broadly and practically—is one indivisible whole. A few other personalities come into the picture: Tom Dorman, with whom I chummed, who was more moustache than flesh and bone; Phineas Abraham, who became a skin specialist; Anthony Bowlby, a friend of mine to the end; and the Sister of Luke Ward, where I clerked, a fine, clever woman, whose photo I still possess.

As I trust this sketch may help along those who now sit where once sat the writer, I add a peculiar incident. My M.D. exam. in the Queen's University (held in Dublin) included a paper on Anatomy that put me to the pin of my collar. Of six questions, three were intricate, and three so simple as to trap the careless. I did not like the look of this paper at all, and I dealt with it very cautiously. Instead of jotting down what I thought I knew and scratching it out again—the disgusting method of the inexpert—I sat for two hours without putting pen to paper, but thinking hard. Certain men—called watchdogs—came and looked me over; turned the blotting-paper, peeped under my chair. A nasty fellow behind grinned and pointed, as friends told me later. Then with one hour in hand I began to write.

* My wife reminds me that the husband sent me a handsome present. Do not take this cynically; I did not.

Three days later I stared at the posted result—a 2nd Honour on my paper! The lesson to be learnt is this: that no examiner of any acumen will give credit to a paper that is confused, erased, and in fact a collection of shots. I take it that little as I wrote, every detail was correct, and that is what counted.

I should like to recall more of these days at Bart.'s, but for the moment I see little more than that I was possessed by a fine frenzy of work, and, except for football, had little spare time. Just as well perhaps. To-day I play golf and write up memoirs and genealogies. But if the Man with the Scythe delays a trifle I hope to visit Bart.'s somewhat oftener in the future, and especially to worry the bio-chemists of to-day as to that peculiar and elusive factor of the cell which we term "Life", and cannot in any practical way define. To none of us does it matter a straw whether the Universe is expanding or contracting, but to watch progress in knowledge of the functions of the intrinsic glands is of real interest.

All studies are easy if tackled wisely. Go in on the top level. Study the latest ideas. They are fascinating; just as one can admire fine cathedrals, ignoring the labour. But we who desire to know the deep reasons of things, build also with stones and mortar, keeping in view the perfect result, the high ideal. This is no obscure parable. It suggests a mode of study.

The high ideal is the antithesis of the inferiority complex. How many are content with inferior work! You see it in the cricket field. Square leg thinks it is enough to push out a clumsy foot to save a boundary. He has not taught himself to throw forward head and shoulders as he runs; to sweep up the ball with one hand; to shy in so that the wicket can be put down and the batsman run out. Or in football, another man tackles in slovenly fashion instead of going intelligently for the ball. Both are content to scramble through their exams. It is all a matter of training the brain—an organ that responds to training quite as well as does the deltoid. The inferiority complex marks inefficient functioning. Shun it like the devil, and cultivate instead the high ideal.

I am moved to add one word more. When a General Officer in the Army, with huge Divisions to watch, and many officers serving under me, the point in the character of each—whether senior or junior—that I hoped to find was *reliability*. Skill, brilliancy, knowledge, experience were all excellent. But to know that once given his work a man might be *relied upon*—within, of course, his capacity—was to me of supreme importance. Now this applies equally to small matters comparatively as well as to greater spheres of work—to the dressing of a surgical case, to the record of a medical. Here, then, is the road to the affections of one's teachers. And here, too, lies the road to Harley Street.

What would one give to tackle life again with the experience already gained! Yet that experience is offered daily by the older men to the younger—and daily ignored. Fools, it is said, learn by their own experience, and wise men by the experience of others. And Carlyle said we are mostly fools. Hard luck, isn't it?

T. M. CORKER.

THE NIGHT NURSE.

THAT I kissed her on my round
An indubitable fact is—
Yes, I know it has been found
An extremely risky practice.
Say that I was drunk, or mad,
Say I might have met Night Sister,
Say just what you like—but add
That I kissed her!

Now I'm married, for that maid
Took that kiss for a proposal,
Nor for one short hour delayed
Making public our betrothal.
I, who'd counted not the cost,
By congratulations harried,
Hesitated, and was lost!
Now I'm married.

Twelve months after was the date
When the final blow descended:
Stern are the decrees of fate!
Learn how my adventure ended,
How I suffered for my sins.
Shrieks of wild Homeric laughter
From my friends when she had twins
Twelve months after!

R. B. P.

MEDICAL EDUCATION FROM THE STUDENT'S POINT OF VIEW.

MUCH has been written in the immediate past on the subject of medical education, both in the JOURNAL and in periodicals of more general circulation; eminent authorities in the various branches of their profession have given their considered and valuable opinions, but the student, mostly on whose behalf this mental effort has been expended, has so far been silent. Most of what follows has been said before (and probably will have to be repeated), but it

may be of interest as representing to a certain degree the feeling from one aspect of the problem.

One of the fundamentals of medical teaching as a whole appears to be the appreciation of the various pre-clinical subjects in their relationship to the future patient. By far the majority of medical students are destined to become general practitioners; this is statistically obvious, yet it seems to have been lost sight of in the many aspects of preclinical teaching. It is not so much that undue insistence is laid on the various subjects as academic subjects, but that not enough stress is laid on them as part of the science of therapeutics. The teachers themselves are all too often pure scientists, especially in the medical schools of the universities, and it is only to be expected that they will have little recollection or knowledge of the application of the subjects they teach. Not only are they pure scientists, but usually highly specialized as well, and this tends more and more to divorce them from the realities of practice. For the average medical student, not only is the wholly scientific aspect often undesirable, but usually rather uninteresting. The clinical point of view has an extraordinary effect of putting life into what, to many, is otherwise moribund study.

The "pure science" method of teaching tends to produce a sense of isolation. The result of this is that students appear in the wards for the first time, just after having passed their anatomy and physiology, with their heads full of irrelevant and isolated facts.

The student has been told at great length about the effects of lack and excess of, say, secretion of the thyroid. But it is rarely considered necessary while studying physiology that he should be brought up into the wards and shown a case of myxœdema or Graves's disease. The whole clinical picture would be so much more indelibly fixed in his memory if a practical illustration in this way were made.

And not only is this true of physiology. The cadaver used for dissection purposes has, of necessity, been preserved and hardened. This process, however, changes the appearance and sometimes the shape and position of some of the organs beyond all recognition. While admitting the impracticability and inadvisability of teaching anatomy from the living subject, surely it would be possible to make use of the post-mortem room more than is so at present. There, at least, the conditions more nearly approximate to those of the living body than in the dissection-rooms.

If it were more firmly kept in mind all through the pre-clinical years that chemistry, physics and zoology should be taught to enable a better understanding of anatomy and physiology, and that these should be taught, not as anatomy and physiology, the academic subjects, but in their application to human beings, the student's future patients, there would be a less feverish and less inadequate attempt to apply the laboriously acquired mass of facts when he enters the wards for the first time.

The syllabus itself is not by any means innocent of faults. This has been enlarged to an enormous extent during the last twenty years, largely due to our greater understanding of physiology and medicine in particular. New work is being published on these and other subjects almost weekly. New editions of the standard textbooks appear regularly every few years. In the prefaces it is the commonest thing to find that the chapter on such-and-such, or the section dealing with so-and-so, has "been considerably enlarged". While admitting that only the elements of the new work have been added, yet it still remains a fact that for the average student there is too much detail expected of him. The danger of this lies not so much in his inability to remember the detail—that, for some reason, is often easy—but in the failure to assimilate the essentials.

This is not only seen in such swiftly progressing subjects as physiology and medicine, but the same state too often exists in the more firmly established sciences, such as anatomy. Surely it is more important to remember the relations of the kidney than the connections of the otic ganglion. Yet it is often the case that the examination candidate will be able, more or less mechanically, to reel off strings of unimportant facts about similar unimportant parts. For the elementary examination in anatomy and physiology, for the ordinary qualifying medical and surgical degrees, it is so much more important to have a grasp of the broad principles of the subject rather than scattered patches of detail and an ignorance of the essentials.

And while there exists for the student a vast amount of relatively unimportant minor points in the curriculum, there is lacking a science of daily growing importance—psychology. While it is not suggested that the aim of medical education is to turn every student into a psychiatrist, the most elementary knowledge of the workings of what passes for the normal mind, including a brief study of the commoner neuroses, would not only make the subsequent study of the psychoses more intelligible, but more important still, would give the general practitioner a much better equipment to appreciate the mental as well as the physical states of his patients. Naturally, most medical men will come up against psychological cases which are beyond their power to treat, unless they be skilled psychiatrists. Then it is all-important that they should have enough knowledge of such disorders to recognize their presence, and be able to advise their patients where expert assistance can be obtained.

If the syllabus of anatomy and physiology were "thinned-out" as suggested above, the inclusion of the elements of psychology with the other preclinical subjects would entail no more work than exists at present. And it would seem that the result would be of more practical value than this part of the syllabus as it stands to-day.

And finally, there is the moot question of examinations. On the face of it there is every reason for their abolition. It is surely quite obvious to most individuals that they often do not show accurately either the amount of knowledge the examinee has derived from his teachers, or how well he will be able to apply that knowledge. There is that well-known class of person who is completely overwhelmed by an examination, and whose mind becomes a blank when asked the simplest question in a *vivâ voce*. There is also the other type, who, by dint of a period of extreme activity day and night for a short time before the paper, can temporarily cram his brain with an adequate number of facts to answer the questions satisfactorily. Though it must be admitted that these two extremes are in the minority, yet it must also be admitted that they do exist. This can be proved by what almost amounts to a platitude—that the best qualified men do not always make the best doctors.

All this has been recognized for many years, and by such famous men as Osler, whose dictum on the subject was quoted in the Editorial of the JOURNAL some months ago. But, as in most things, destructive criticism is notoriously easy, and constructive criticism equally notoriously difficult. What is to be substituted for the present examination system? The substitute should be impersonal, and it should be a test, not in the accepted sense of the word, but one which extends through the whole of the student's training—a prolonged observation, so to speak, in order to avoid the highly abnormal environment of the examination.

What system is likely to fulfil these conditions? Personal reports sent in to a central committee or board regarding the work and progress of each student from their immediate chiefs have been suggested. But in such a system, impersonality in every case would be too much to expect, even of the physicians and surgeons on the staff of this hospital.

It appears at present that the examination system must remain unchanged, for lack of something better, and for that reason only. But even so, much can be done in the matter of papers, and the questions set. They could and should be of an entirely practical and applied character.

It appears, then, that the syllabus and the methods of teaching of the preclinical subjects could be altered with some advantage, but it is difficult to suggest any adequate alternative for the present examination system.

J. E. H. S.

STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

ST. BARTHOLOMEW'S HOSPITAL *v.* CAMBRIDGE UNIVERSITY.

Played at Winchmore Hill on October 25th. Lost, 21—5.

There is a song which used plaintively to be sung by Messrs. Flotsam and Jetsam entitled "Must it always be so?" which found an answering echo in the hearts of those Hospital supporters present who remembered the games against Cambridge during the past few years when, their hopes raised by the closeness of the score and the vigour of the Hospital attack, they were exalted, only to be cast down, in the last minutes of the game, to the despair of a heavy defeat by an unexpected plethora of tries.

This year was no exception, but though Cambridge contrived to finish in the typical way, it would be unfair to suggest that it was a "heavy defeat", or that their score was a fair criterion of the run of the play.

The first half of the game was, as we have come to expect, closely fought; the Hospital pack showed a co-ordination and spirit which easily held, and later dominated, the Varsity forwards, who, without R. B. Jones and Leather, were frequently shoved in the tight scrums, well marked in the lines-out, and demoralized by series of irresistible rushes led by Darmady.

Despite this early pressure, the Hospital three-quarters found it impossible to get into their stride, and Cambridge had no difficulty in reaching their opposing centres and frequently turning defence into an attack, which, had it not been for Morison, might have earned them a substantial lead; as it was, Johnston, after twenty minutes' play, opened the 'Varsity score with a try in the corner, which was not converted.

The Cambridge backs made every effort from their fewer chances, and Dick, finding an opening which he exploited to the full throughout the remainder of the game, burst through and ran strongly to give the 'Varsity an 8-point lead at half-time.

Although the Hospital forwards played with undiminished vigour throughout the second half, the backs remained incapable of turning to good account the opportunities presented to them, and their defence, which up to this point had been adequate, began to lack finality—a fault which Dick soon demonstrated by shaking himself free from a half-hearted tackle and giving Fyfe a clear run for a try, which Parker converted.

With a large lead Cambridge were inclined to takes risks, and Mundy, snapping up a wild pass which Jones failed to hold, ran through to give Capper an inside pass on the 'Varsity line and the Hospital its only score. Morison succeeded with the kick.

For some time after this heartening piece of opportunism play remained level, and though the Hospital forwards brought off several effective "wheels" with a bellicose Wilson close behind, tradition was not to be denied, and with only a few minutes left Cambridge brought their score to 21 by two incisive openings by Dick, from one of which Fyfe scored an unconverted try, and the other, a brilliant combination in the centre, resulting in a try by Jones, which Parker again converted.

ST. BARTHOLOMEW'S HOSPITAL *v* WASPS.

Played at Sudbury on October 28th. Lost, 11—5.

The appalling weather conditions which prevailed throughout the afternoon were sufficient for faulty handling and inaccurate kicking, but, while hampering the Hospital backs, they seemed a positive asset to the unbeaten Wasps, who, in pouring rain, passed the ball with ease and accuracy, making every effort to open up the game—a policy which earned them a deserved victory.

The Bart.'s forwards, with Moynagh taking Capper's place in the back row, played hard, but failed to show the cohesion which had been the feature of their play earlier in the week, and, while holding their own in the tight scrums, were aimless and inclined to overkick the ball in the loose.

The Hospital were unlucky not to score early in the game, when Nel was pushed into touch by the corner flag, following a three-quarter movement which was remarkable for its unexpected perfection;

but a few minutes later Nel, following up a kick ahead, and appearing rather as a vision to two leisurely defenders, gathered the ball and passed inside to Swinstead, whio scored by the posts; Morrison kicked a goal.

For some time after this play remained unexciting, but the predominance of the Wasp pack gradually became marked, and from a line-out in the Hospital "25" a forward broke away to score an unconverted try. The Wasps maintained a steady pressure in the second half, relieved by some lengthy kicks by Morison and an occasional forward rush; but the pressure told, and eventually Cooke darted round the blind side and scored an unexpected try in the corner, the kick failing. A few moments later a defensive kick on the part of a Bart.'s back was charged down, the ball falling straight into the arms of an opposing centre, who, unmarked, ran through to score under the posts, there being no mistake with the easy kick.

The team-work of the Wasps, with their ability to control the greasy ball among their backs, was the deciding factor in their victory, and contrived to show up the lack of combination in the Hospital three-quarters, who, except for one occasion, never looked dangerous.

Darmady, Newbold and Swinstead were always prominent among the forwards; Wilson, while going down on the ball with praiseworthy monotony, was inclined to receive the ball, put his head down and butt.

Of the backs Fairlie-Clark's tackling was notably sound; Youngman, isolated on the left wing, went to look for work, and Morison, whose fielding of the greasy ball was a joy to watch, maintained his usual length and accuracy.

ST. BARTHOLOMEW'S HOSPITAL *v.* UNIVERSITY COLLEGE, DUBLIN.

Played at Winchmore Hill on November 11th. Drawn, 0—0.

This game was to return a visit made by Bart.'s to Ireland two years ago, when, having been lavishly entertained, we narrowly defeated the College by a conversion by Darmady which should go down to posterity in the annals of the Hospital's Rugger.

The Irish team, on a short tour, had beaten London University and been narrowly defeated by Glasgow University, and had it not been for the work of the Hospital's forwards and the improved play of the backs, would have added Bart.'s to their list of international conquests.

The game was fast and open, and though both sides had opportunities and strove hard, the final pointless result was a fair comment on the equality of the two teams and their defence.

The superiority of the Bart.'s forwards in the tight scrums and Hunt's very successful hooking were balanced by rushes of the traditional type by the College forwards and, though without McMahon, their greater thrust behind the scrum. Despite our forward advantage and the large share of the ball which we had, the sound tackling of the Irish prevented our wings, rusty from long disuse, from getting into their stride, many attacks during the first half breaking down under accurate and forceful marking.

We were, however, unlucky not to score when Morison, from a penalty kick, landed the ball on the crossbar, from which it rebounded into Mundy's arms, only for him to be brought down on the line.

The College forwards commenced the second half with some typical rushes, which took the ball well into our territory, and kept up considerable pressure, from which only our improved defence prevented a score.

However, one of Wilson's occasional phenomenally long kicks regained the lost ground and our aggression, from which, after a long period of barren endeavour, we retired pointless, to finish the remainder of the game in our own "25".

Of a great improvement we may be justly pleased—the forwards well together, packed low and heeling cleanly, gave the backs every chance; Wilson, though working hard, lobbed his passes and had some difficulty in finding Little, who showed a tendency towards inaccurate passing with one hand. Fairlie-Clarke never missed his man and made some clever openings, but, with Pirie, appeared to stand too far away from Little, thus sacrificing, by slow and unwieldy passes, the speed on the wings, who, though hampered in this way, made the most of the light diet which they received after their long starvation.

Among the forwards Darmady and Jackson used their feet to good advantage, Newbold and Mundy were always well up, while Grey, like an anarchist's bomb, was hidden away in quiet places where he did a great deal of damage.

The College team were afterwards entertained to dinner at the "Cheshire Cheese".

ST. BARTHOLOMEW'S HOSPITAL *v.* ARMY TRIAL XV.

Played at Winchmore Hill on November 15th. Lost, 6—5.

Though without Capper, Swinstead and Nel, the Hospital showed further improvement, and though the forwards failed to pack as low and as tightly as the Army, they were able, through the inspired regularity of Hunt's hooking, to give the three-quarters ample opportunities and some much-needed practice.

Pirie, finding his form, was the prime mover in attack and made several openings, from one at least of which the Hospital should have scored. Wilson and Little were unable to combine very effectively, but the forwards, on heavy ground, played hard and were really dangerous in the loose. There was no score at half-time, Morison having failed narrowly with a penalty kick and Wilson, standing on tip-toe, managing to touch the ball from an otherwise successful drop-goal by Glass.

Following some loose mauling on the Hospital line, the Army scored an unconverted try at the commencement of the second half. This play was, for some time, a series of scrums, from which Bart.'s did some very effective wheels, but, except for a breakaway by Mundy, well backed up by Jackson, were unable to gain much ground.

Unwin scored again for the Army. A little later the same player broke away unmarked, but was overtaken and brought down by Morison, who once again proved himself equal to even the most exacting emergencies. The Hospital forwards kept the ball well in the Army territory, and from a scrum Wilson went through to give a reverse pass to Jackson, who scored a try by the posts, which Morison converted.

ASSOCIATION FOOTBALL CLUB.

ST. BARTHOLOMEW'S HOSPITAL *v.* DOWNING COLLEGE, CAMBRIDGE.

Played at Cambridge on Saturday, October 21st. Lost 1—3.

During the first few minutes Downing pressed hard, but some good saves by McKane prevented them from scoring. Eventually, after more persistent attacks, their inside left scored with a hard low shot into the left-hand corner of the goal. Shortly afterwards Downing added another goal through their inside right. Play for some time became ragged, then Shackman gave a low pass to Dolly, who centred, but the ball was intercepted by their right back. The ball came clear and Waring took a long dropping shot, which forced their goalkeeper to deflect over the cross-bar. Dolly took the corner kick and Pearce scored from close in. Before half-time came Downing added a third goal, thus making the score 3—1 in their favour. There was no scoring in the second half, and few constructive movements. The Hospital forwards did not show up to advantage, and hardly ever appeared dangerous. At the same time our defence subdued the Downing attack, and deserve praise for preserving an intact goal, despite an injury to Ogilvie, who was a passenger during the closing stages.

There can be little doubt that the best side won, and this cannot be called one of the Hospital's best displays.

Team.—T. O. McKane (*goal*); G. Herbert, J. D. Ogilvie (*backs*); J. W. B. Waring, D. R. S. Howell, W. M. Maidlow (*halves*); C. Nicholson, N. H. Bloom, H. A. Pearce, R. Shackman, R. C. Dolly (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL *v.* KEBLE COLLEGE, OXFORD.

Played at Oxford on Saturday, October 28th. Won 2—1.

The Hospital won the toss, and, kicking off with the wind and the rain behind them, attacked from the start. Indeed, for the first fifteen minutes of the game the Bart.'s defence, as such, saw nothing of the ball, and Hunt was seen among the forwards. The Keble goal-keeper was good, but he was quite unable to prevent Bart.'s first goal, which came after ten minutes. Owen gave a good pass to Nicholson, who beat two men and centred cleverly, for Royston to score a first-class goal from close in.

Bart.'s continued to have the better of the play and attacked most of the time, the home team only appearing dangerous on one occasion. Cooper was settling down in the Hospital forward line, and once had the ball in the net. This goal was not allowed, however, as Cooper had somewhat blatantly handled the ball immediately before, thus giving the referee genuine excuse for blowing his always prominent whistle. Our inside forwards missed a good chance of scoring shortly afterwards, and attacked without further success until half-time.

The ball was kept mostly at the Keble end of the field during the second half, and Dolly scored another goal, after the Keble outside

right had scored from what appeared to be an offside position. There was no further scoring, although the Hospital had the better of the game territorially. The forwards were excellent in approach work, but must improve near goal. Brownlees was outstanding at inside right, while Cooper made a good *début* at inside left. Owen played as well as any of this season's wing halves, and McKane handled a greasy ball with confidence.

Team.—T. O. McKane (*goal*); G. Herbert, A. H. Hunt (*backs*); W. A. Owen, D. R. S. Howell, W. M. Maidlow (*halves*); C. Nicholson, P. Brownlees, G. R. Royston, F. E. Cooper, R. C. Dolly (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL *v.* BALLIOL COLLEGE, OXFORD.

Played at Winchmore Hill on Saturday, November 4th. Won 2—1.

Bart.'s kicked off with the wind, and were soon attacking. A corner was forced on the right, and from the kick the ball went to Maidlow, who put in a fine first-time shot, the ball entering the top right-hand corner of the net. Balliol took some time to settle down, their attacks being broken up at the start by the Hospital defence. Bart.'s, on the other hand, attacked frequently, and Royston was close to scoring more than once. He also distributed the ball well, and several good movements imperilled the visitor's goal. However, there was no further score before half-time.

Balliol had slightly more of the game in the second half, but showed decided weakness at inside-forward. Nevertheless they were able to score from close in, fifteen minutes from the end, and it began to look as if they would snatch an undeserved draw, as the strong Bart.'s attacks met with no reward until the last minute. Then Maidlow scored again with a precisely similar shot from thirty yards out. This proved to be the last kick of the match, and thus Bart.'s scored a thrilling win through the opportunism of the left half.

The Hospital defence played well on the whole, Dolly being exceptionally good in his unusual position at full back. He was missed in the attack, however, as Pearce was not so successful as he has been in the past.

Team.—T. O. McKane (*goal*); G. Herbert, R. C. Dolly (*backs*); E. G. Tuckwell, D. R. S. Howell, W. M. Maidlow (*halves*); C. Nicholson, P. Brownlees, G. R. Royston, R. Shackman, H. A. Pearce (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL *v.* READING UNIVERSITY.

Played at Reading on Saturday, November 11th. Lost 4—6.

Bart.'s won the toss and took advantage of the sun and slight slope of the ground. During the first twenty minutes the opposing team produced some really first-class football and were undoubtedly complete masters of the game. Their low and accurate passes temporarily bewildered our defence, with the result that they scored three goals in quick succession from brilliant first-time shots, all of which gave McKane no possible chance. Their centre forward scored two and their inside left the third goal. After this series of misfortunes the home side settled down and played with ever-increasing confidence. The forwards attacked and went near to scoring when Brownlees shot over the cross-bar. Reading University, however, scored a fourth goal through their centre forward, resulting from a clever movement on the left wing. A few minutes later Bart.'s were attacking fiercely. Dolly, on the left wing, shot low and hard, but the ball was intercepted by their right back, who was unable to clear successfully, and Royston scored with a magnificent drive to the top corner of the goal. Half time arrived with the score still 4—1 in their favour.

The second half proved to be full of excitement. The Hospital made every effort to fight hard with the most encouraging results. In a very few minutes Brownlees dribbled the ball cleverly up the field and shot low, causing their goal-keeper to fall in an effort to bring off a good save, but he was unable to gather the ball sufficiently cleanly to effect a safe clearance and Royston scored again from close in. From the kick-off immediately afterwards Royston secured the ball and passed to Gilbert, who then gave a beautiful low pass to Brownlees. Brownlees continued the movement with clever dribbling and gave the ball back to Gilbert, who, after defeating their last line of defence, shot into the corner of the goal. The inside forwards are to be congratulated on this perfectly executed movement.

The opposing team, however, carried the score to 6—3 with further goals from their inside right and centre-forward, but in spite of this Bart.'s still attacked again and again, scoring once more through Royston from close in. The score remained 6—4 in their favour to the end of the match—a game which was fast and keenly fought throughout.

The team on this occasion showed very promising progress. The forwards played well; Royston and Gilbert were good. Brownlees at inside right played an excellent game. Hunt was always outstanding in the defence, his headwork being superb. McKane in goal made many good saves and played well, though with better anticipation he might have saved the last two goals. The halves showed much improved form.

Team.—T. O. McKane (*goal*); A. H. Hunt, G. Herbert (*backs*); J. W. B. Waring, D. R. S. Howell, W. M. Maidlow (*halves*); C. Nicholson, P. Brownlees, G. R. Royston, R. G. Gilbert, R. C. Dolly (*forwards*).

REVIEWS.

INDIVIDUAL PSYCHOLOGY PAMPHLETS (No. 9): INDIVIDUAL PSYCHOLOGY AND PSYCHOSOMATIC DISORDERS (II). (London: The C. W. Daniel Company, 1933.) Price 2*s.* 6*d.*

The first paper, by Dr. J. S. FAIRBAIRN, deals in an interesting way with individual psychology as met with in the practice of midwifery and gynæcology. The mental attitude of the expectant mother, towards herself or towards her husband, often needs correction; the impression that she is an invalid should always be discouraged. After the birth of the baby even greater mental care may be required, especially if the progress of the child is unsatisfactory. Dr. Fairbairn, like so many others, bewails the fact that less and less consideration is given to the personality of the patient as more and more is discovered about each separate organ, and that in this respect gynæcologists are perhaps not the least offenders. The psychical element in many cases of spasmodic dysmenorrhœa and vaginismus is well known, but not always stressed sufficiently in the textbooks or in treatment. Abdominal discomfort and backache being so common amongst middle-aged women, many operations must be done which are really unnecessary —"what a temptation the reproductive tract is to the mechanically minded, for its integrity, although essential for the perpetuation of the species, is not necessary to the life of the individual, and its component parts can be removed, wholesale or piecemeal, or re-arranged to taste, almost without an appreciable risk to life"—a point well illustrated by the case of a lady, forty years of age, who, in fifteen years of unhappy and childless married life, had undergone no less than ten surgical operations between the umbilicus and the perinæum!

The value of the work of the school of individual psychology in attempting to bring psychological problems within the understanding of ordinary mortals must be manifest to all; how much is this value enhanced if it also exposes and helps to reduce the number of fantastic theories one sometimes hears, as an example of which Dr. Fairbairn quotes: "I heard, seriously stated at a discussion on the psychology of the infant, that the constipated baby saved up its motions for the satisfaction of passing one really big one, and that this habit showed the possession of a retentive mind. . . ."

Mr. W. MCADAM ECCLES approaches the subject from a different point of view; as a surgeon he presents his paper in the form of a drama, before, during and after an operation, in which the leading parts are played by a surgeon, an anæsthetist and a patient.

As one who was recently associated with the nursing of the author through a major surgical operation, the reviewer was particularly interested in this part of the pamphlet. Mr. Eccles stresses the fact, often forgotten, how much these three actors may help each other in small and sometimes unexpected ways. To a patient, the day fixed for his operation seems, at the time, the most unpleasant moment of his life. For his comfort, a good night's sleep and punctuality in the time of pre-operative injection are all-important; a short visit from the anæsthetist the day before, and on the fateful morning a cup of tea made really well, are additional details always appreciated.

The patient himself must do his own share; unfortunately it is not always realized how much his full co-operation and patience are essential, not only for the smooth running of the drama as a whole, but also for the comfort of the players.

RECENT ADVANCES IN RADIUM. By W. ROY WARD, M.B., B.S., M.R.C.S., and A. J. DURDON SMITH, M.B., B.S., M.R.C.S. (London: J. & A. Churchill, 1933.) Pp. viii + 324. 4 coloured plates and 140 illustrations. Price 21*s.* net.

A work must almost amount to a full textbook that purports to describe all the recent advances in a subject with as short a history

as radium therapy. Perhaps for the general student some of the detail might be too technical, but there is very little in this book that any surgeon can afford to ignore.

The subject has only lately grown from the childhood of empiricism to the stature of rational science. Among the enthusiasts and critics always associated with such a change, the authors take a balanced point of view of the efficacy of the treatment.

Naturally the larger part of the book describes the methods and results of radiation in connection with malignant disease. To this, ten of the twenty-two chapters are devoted. The introductory chapters discuss the physics and production of the element, with an outline of the general methods and forms of apparatus used. The book concludes with four chapters on non-malignant conditions and two full indices of subjects and authors. It is impossible in the space of a review to deal with the various subjects separately. It will be enough to say that every recognized worker receives full consideration, and the details of each form of procedure is carefully described.

There is an excellent series of paired photographs showing the conditions treated, and the effects of radiation after periods varying from two months to a year; in each case also the end-result is stated. Besides these, there are a number of X-ray photographs showing phases in treatment, and several diagrams illustrating technique and the instruments used. Full references are given in each section.

The work surpasses even the standard of its fellows in the "Recent Advances" series, both in content and in general appearance.

Contents.—Part I: General—Physics—Action of Radiation—Radiosensitivity—Dosage—Apparatus—Protective Measures—Mass Radiation.

Part II: Breast—Uterus—Tongue—Lip, Cheek, Jaws, etc.—Larynx, Œsophagus, etc.—Rectum and Anal Canal—Skin, etc.—Bladder and Prostate—Eye—Sarcoma.

Part III: Papilloma, Hyperkeratosis, Keloid, Lupus—Angioma—Tuberculous Adenitis, Leukæmia, Lymphadenoma—Uterine Hæmorrhage.

EXAMINATIONS, ETC.

University of Oxford.

The following Degrees have been conferred:

B.M.—Beal, J. H. B., Fowler, E.

University of Cambridge.

The following Degrees have been conferred:

M.D.—Nelson, H. P.
M.B., B.Chir.—Elliston, W. A., Thomas, G. W.
M.B.—Barnes, C. O., Radcliffe, F.
B.Chir.—Briggs, G. O. A., Cohen, E. L., Gawne, D. W. C., Langford, A. W.

Royal College of Physicians.

The following have been elected **Fellows:**

Burke, G. T., Cumberbatch, E. P., Myers, B. E.

The following has been admitted a **Member:**

Page, A. P. M.

Royal Colleges of Physicians and Surgeons.

The following Diplomas have been conferred:

D.P.H.—Lakshmanan, C. K.
D.T.M. &H.—Cook, A. B.

Conjoint Examination Board.

Pre-Medical Examination, October, 1933.

Chemistry.—Rikovsky, T. P., Storey, T. P.
Physics.—Kumar, M., Rikovsky, T. P.
Biology.—Moynagh, K. D., Rikovsky, T. P., Vyrnwy-Jones, D. A.

First Examination, October, 1933.

Anatomy.—Hicks, W. R., Horner, W. M. L., Howell, D. R. S., Jeremy, W. H. R., Moxon, T. H.
Physiology.—Alexander, L. L., Horner, W. M. L., Jeremy, W. H. R., Moxon, T. H., Scott, K. B.
Pharmacology.—Bird, G. E. N., Mills, P. J. W., Mundy, R., Philip, D. N., Prewer, R. R., Samuel, R. G., Wilson, J. D., Wooding, J. E.

Final Examination, October, 1933.

The following students have completed the Examinations for the Diplomas of **M.R.C.S., L.R.C.P.**

Blusger, I. N., Cartwright, W. H., Chester-Williams, T. L., Chivers, J. A., Corea, F. E., Davies, D. O., Edwards, L. J. L., Houlton, A. C. L., Race, R. R., Sedleigh-Denfield, G. R., Shackman, R., Shields, J., Shulman, I. M., Smart, J., Telfer, W. P. M., Thomson, D. M., Wheeler, F. E.

L.M.S.S.A.

Primary Examination, October, 1933.

Anatomy.—Mills, C. W.

CHANGES OF ADDRESS.

DYMOND, G. H., 219, New King's Road, Fulham, S.W. 6. (Tel. Fulham 0395.)
ELLISON, P. O., 137, Harley Street, W. 1. (Tel. Welbeck 3956.) Buckhurst, Gerrards Cross. (Tel. Gerrards Cross 582.)
FELLS, R. R., 17, Mortimer Road, Clifton. (Tel. Clifton 36623.)
GRIFFIN, F. W. W., 38, Gunterstone Road, W. 14. (Tel. Fulham 5317.)
HARTLEY, Sir PERCIVAL HORTON-SMITH, 29, Portland Place, W. 1. (Tel. Langham 3828.)
KERSLEY, G. D., 1, The Circus, Bath.
MACVINE, J. S., Central Middlesex County Hospital, Acton Lane, Willesden Junction, N.W. 10.
PALMER, C. SPENCER, 7, Windlesham Gardens, Brighton.
SANDERSON, C. J., "Chalfont", Lower Willingdon, Sussex.
STURTON, C., Montagu Street, Kettering.

APPOINTMENTS.

MACVINE, J. S., M.B., B.S.(Lond.), appointed A.M.O. to the Central Middlesex County Hospital (Middlesex County Council).
MORGAN, GLYN, M.B., B.S.(Lond.), appointed Honorary Obstetric Physician and Gynæcologist to the Royal Gwent Hospital, Newport, Mon.

BIRTHS.

BEDDARD.—On November 5th, 1933, at 13, Barn Hill, Stamford, Lincs, to Betty (*née* Welham), wife of Dr. Roger Beddard—a daughter (stillborn).
REES.—On October 18th, 1933, at 27, Welbeck Street, W. 1, to Isabel, wife of T. P. Rees, M.D., of Corngavar, Warlingham, Surrey—a son.

MARRIAGES.

BENNETT—ROWLES.—On October 31st, 1933, at St. Botolph's Church, Chevening, Kent, Randle Bennett, M.R.C.S., L.R.C.P., eldest son of Dr. C. H. Bennett and Mrs. Bennett, of Sandbach, Cheshire, to Dorothy Margaret, only daughter of the late F. L. Rowles and of Mrs. Rowles, of Riverhead, Sevenoaks.
BLOXSOME—BAULD.—On October 28th, 1933, at Cheltenham, Harold Bloxsome, M.R.C.S., L.R.C.P., of Fairford, Glos, to Helen, second daughter of Mr. and Mrs. W. Bauld, of Glencraig, Fife, and Dundee.
COLE—BURT.—On November 1st, 1933, at St. Mark's Church, North Audley Street, Dr. T. E. C. Cole, of Leamington Spa, to Miss Gwendolen M. Burt, elder daughter of Mr. and Mrs. H. R. Burt, of Queen's Avenue, Muswell Hill.

DEATH.

WALDO.—On November 2nd, 1933, at 40, Lansdowne Road, Holland Park, W. 11, Frederick Joseph Waldo, M.A., M.D.(Cantab.), Barrister-at-Law, of the Middle Temple, late Coroner for the City of London and Borough of Southwark, aged 81.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, E.C. 1.*

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